



# California's Health

Vol. 12, No. 22 • Published twice monthly • May 15, 1955

## OUR DEDICATION TO IDEALS\*

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"Ideals, if they survive the high mortality of youth and adolescence which few of them do—turn, like tadpoles, into a different shape as they approach maturity."

This quotation from Frederick Oliver's "Endless Adventure" is appropriate in this dedicatory setting.

Our California State Department of Public Health is the idealism of many hundreds of men and women. After a most auspicious birth, it nearly succumbed in its neonatal period. Subsequently, it has passed through many shapes and forms, until it emerges today in the strength of maturity. It is fitting that today we should center our ceremonies on our illustrious heritage. This is not for smug complacency. In this tribute to the vision and fortitude of the past's idealism, we strengthen our own as we confidently face the future.

The history of the Board and Department of Public Health has been prepared admirably by Marguerite Augustine of the Bureau of Health Education with the notable resource assistance of another idealist, Ida May Stevens of the Bureau of Acute Communicable Diseases. Today, I shall attempt a panorama, singling out major events when the ideals of our leaders meshed with the needs and resources of society to effect a major shift in the shape and form of our department.

Of course, primary attention must focus on the birth of the board. Only six months after Massachusetts established the first State Board of Health,

California followed. On March 18, 1870, the Legislature established the board. On April 22, 1870, 85 years ago last Friday, the first board meeting was held. Unquestionably, this was the accomplishment of a single man,



Charles E. Smith, M.D., President, California State Board of Public Health, delivered the Dedication Address at the department's dedication of its new headquarters building in Berkeley April 28, 1955. To his left on the speaker's stand is Malcolm H. Merrill, M.D., State Director of Public Health, and Wilton L. Halverson, M.D., former director of the department (1943-1954), under whose administration plans for the new building were begun. More than 1,000 persons attended the dedication.

Thomas Muldrop Logan.\* Under Guy P. Jones† impelling enthusiasm, Dr. Logan's accomplishments are well known. The co-founder of the California Medical Association and Califor-

nia's first President of the American Medical Association, Dr. Logan was an orator, scholar, scientist and, above all, an idealist. At that first meeting of the board, committees were established on the health of public institutions, schools, prisons and factories, on biostatistics emphasizing the healthfulness of varying localities and occupations and on the "effects of intoxicating liquor upon the industry, prosperity, happiness, health and lives of the citizens of the State."

Evidently, committee action is part of public health's autonomic nervous system. The board plunged into a very active program of biostatistics, epidemiology with special emphasis on communicable disease control, sanitation, public health administration, maternal and child health, dental health, occupational health, venereal disease control and alcoholism, all focused through health education. Logan recognized the necessity not only of full support of the medical profession, but also of inserting public health into the curriculum of the medical schools and of the entire University as well. Within two years the Regents of the University of California established a professorship in sanitary science and appointed Logan to it "so that every graduating class can go out properly informed in the great art of preserving the individual and the public health." This course is outlined in the Second Biennial Report of the Board of Health.

Thus, the pattern of close relationship between the state board and its department with the University is manifest from the beginning and ap-

\* Logan, Thomas M., M.D., organizer and first secretary, California State Board of Health, 1870 until his death in February, 1876.

† Mr. Jones joined the department in May, 1911, as morbidity statistician and later became assistant to the secretary. He also served as chief of public health information services and chief of the vital statistics unit. From 1922 to his retirement in May, 1945, he was editor of the department's publication the *Weekly Bulletin*, which in 1943 became *California's Health*. Mr. Jones also authored "Highlights of Public Health in California" (manuscript) 1946.

\* Presented as the Dedication Address at the dedication of the Headquarters Building, State Department of Public Health, 2151 Berkeley Way, Berkeley, on April 28, 1955.

appropriately culminates in this congenial setting of our headquarters building.\* It fits logically into Logan's vision. Think, if you will, of Logan's description of the instructional area which he entitles *Mental Hygiene*:

"The word, hygiene, in its largest sense, signifies rules for perfect culture of mind and body; it is impossible to dissociate the two; the body is influenced by every mental and moral action; the mind is profoundly influenced by bodily conditions. \* \* \*

Logan's experiences and successes in California led him to expand and extend his programs nationally. When the American Medical Association met in San Francisco in 1871, Logan introduced and the association adopted a series of resolutions regarding "the Science of Hygiene and Preventive Medicine \* \* \* having in mind the greatest good of the greatest number" and recommended "a distinct and separate chair, independent of physiology to be established in all our medical schools."

Another Logan-propelled A. M. A. resolution was for the establishment of a State Board of Health, following the example of Massachusetts, "as one of the oldest, most enlightened and conservative," and of California, "as one of the youngest, most progressive, and enterprising members of our glorious confederacy."

Logan made such a name for himself that the following year he was elected President of the American Medical Association. His Presidential Address at St. Louis, May, 1873, is a prophetic gem of idealism. His keynote was public health. Besides amplifying the preceding points, he urged establishment of a National Sanitary Bureau to complete the pattern of federal, state and local health departments. Furthermore, he recognized the necessity of adequate salaries to attract the most able in order to devote their full time to their duties. His elegant description of the reasons why health officers must be full-time cannot be improved. Thus:

The proper organizational pattern "would also make (public health) an object of ambition with our best qualified members (of the medical profession) to enter into the public service,

provided a sufficient pecuniary consideration be appropriated by the Federal and State Governments, to render them independent of private practice. The reasons for this provision are, first: because the claims of such practice would be constantly adverse to those of public duties, especially at times of epidemic disease, when official activity would be most needed; and secondly, because the personal relations of private practice might render it difficult for an officer of health to fulfill with impartiality his frequent functions of complainant; and thirdly, because, with a view to the cordial good will and cooperation of his medical brethren, it is of paramount importance that the officer of health should not be their rival in practice, and that his opportunities of admonitory intercourse with sick families should not be liable to abuse for the purposes of professional competition."

With the same philosophy which imbued Elias Cooper Lane in establishing the Lane Popular Medical Lectures, Logan's presidential address became evangelical upon the role of health education. If we recall the then current suspicion in which "medical publicity" was held, we appreciate Logan's courage as well as his vision: "The science of hygiene is not above the people but of them. \* \* \* Let us throw away all puerile notions about the dignity of our calling, and approach the people through the only channels by which they can be reached—the newspaper and the lecture room. This is our work for the future—to educate the people."

Logan's ideals are epitomized in his conclusion:

"Service—service to humanity—will evermore in medicine, as in all other departments of human pursuits, be the certain key to lasting honor and high reward."

In 1876, at the zenith of his career, Logan died of pneumonia. His funeral was a state occasion, with participation by the Governor and all civic and state political leaders and an eloquent resolution of condolence by the Legislature. With his death his superb ideal of public health began to weaken. The tiny tadpole had been nourished only by the yolk sac of Thomas Logan and had not yet learned to feed from the communal environment. Logan had

not realized that enduring health education is not effected solely from the lecture hall and the newspaper. So his beloved state board faltered, its prestige dimmed and it nearly perished. An index is the biennial report which shrank from fascinating reports and eloquent addresses to a few pages of drab statistics.

Then bubonic plague in San Francisco created a crisis in which public health could not be ignored and Dr. N. K. Foster\* appeared, imbued with his high ideals. When plague was recognized in 1900, the State Board of Health admitted its presence. However, political pressures became so severe that the board reversed itself and declared that the disease was not plague. With 110 proved plague cases and 105 deaths and with the Federal Government poised to quarantine the State, plague became a paramount state-wide as well as local San Francisco issue. One is reminded of the threat of political impact of smog last fall where, fortunately, Governor Knight recognized not only the existence of the problem but also the public resource of the State and Nation in meeting it; therefore, smog and public health did not suffer political road blocks.

However, at the turn of the century Governor Gage determined to ignore plague, appointing a board which denied plague's existence. He was defeated for re-election in 1902 by Dr. George C. Pardee who fully appreciated the gravity of the plague situation. When Governor Gage had appointed his pliable board, he had neglected the then necessary confirmation by the Senate. Therefore, the new Governor merely withdrew the nominations and swept out all of the old board except for Dr. Matthew Gardner, who died almost at once.

As we all know, the new board played its important role in recognizing and coping with the problem of plague. In the renaissance of the board, Dr. N. K. Foster played the major role. His vision and courage in the face of overwhelming adversity, his integrity in holding to his ideals, are inspirations to us. We are privileged to have from Guy Jones the original hand-written speech given by Dr. Foster, describing his experiences.

\* Foster, N. K., M.D., State Health Officer, 1903-1909.

\* The department is located just off the university campus and across the street from the School of Public Health.

"On April 1st (1903) the new board met with the old and after the old had closed up their business—the new one organized and I had the honor to be elected secretary and executive officer.

"After adjournment, I called on my predecessor, who had his desk in the office of the State Lunacy Commission, and asked for the property of the board. With a quizzical look he said, 'property of the board, it has no property. That desk is mine and every scrap of paper in it.' He did, however, give me a bunch of letterheads \*\*\* and said, 'Sit down and I'll give you some advice.' I was receptive, thinking to get some pointers on the work.

"Instead, 'You have a good practice; stay with it. Have someone open your mail and attend to it. Come once a month to draw your pay and show yourself and let me show you how to make out your expense account for your trip.'

"He proceeded to put down some items, some of which I had, some not. Dinner \$5 and everything in proportion.

"I said, 'But, Doctor, it didn't cost that much.'

"'Oh! that doesn't matter. You have \$1,500 a year to spend on the expenses of the board and you have to get rid of it. You might as well have it as anybody.'

"Not a bright outlook and I went to my room in none too happy a mood. No desk, no chair and no place to put them if I had."

Dr. Foster then describes how he shared desk room with the Secretary of the State Board of Examiners in the Lieutenant Governor's Office. His description continues:

"The janitor rustled me a desk and chair and I turned to the pile of old state reports. With them I found many unopened letters and this gave me a start to work. Some were months old and some had in them stamps to insure a reply. I didn't blame one doctor who was acting as best he could as health officer in his village for using some pretty powerful language. He said, 'This is the third time I have written and have no reply and by \*\*\* it is the last.' I replied that a new deal was ordered and that in the future he would get some sort of a reply by return mail.

"Do you blame me for feeling lonely and blue? I had given up my practice and had broken up my home believing I was to fill or try to fill an office of honor and I found nothing but disgrace abroad and contempt at home.

"\*\*\* In those hours of discouragement I saw the futility of my working without the aid and cooperation of others throughout the State. An account of the June 3d Plague Conference in Washington where we fought it out and instead of a quarantine got a resolution of confidence has no place here.

"It was a busy spring and summer I spent trying to arouse interest in public health matters. I attended all the medical societies I could, visited the different health officers and answered all calls for help in person. I met with willingness everywhere, but a good deal of incredulity that the State Board of Health was anything but a political sinecure. \*\*\*

"The executive officer of the board at that time had most of the work to do. There were no assistants, not even a stenographer but never was such an officer backed by a better board. \*\*\* The need of organization was always making itself felt. \*\*\* It was everyone for himself. In July (1903) I began writing to different health officers and doctors to ask their views on an association. The response was favorable and we called the first meeting for September 8, 1903, at San Francisco. The attendance was good and the name 'State, County and Municipal Sanitary Conference of California' chosen. The next meeting was held in Paso Robles April 18, 1904." (It is interesting to note that conference is used in the title and that the fall-spring pattern is now followed by our Conference of Local Health Officers.) Governor Pardee addressed the Paso Robles meeting and is directly quoted by Dr. Foster as follows:

"The objects of the conference are to discuss questions relating to public health, to exchange ideas in regard thereto and to establish throughout the State a concord of action so that there can be some uniformity in the words to bring organization out of work—in other words to bring organization out of chaos."

Now the public health ideal was nurtured well by solid support throughout California. There was close liaison, too, with the university. The State Board of Public Health grew in prestige, served by able secretary-executive officers. However, Logan's ideal of full-time local health officers still was lacking. Just prior to World War I the secretary, Wilbur Sawyer,\* set about organizing districts headed by full-time teams. This was the beginning of the new era of expanding and strengthening local public health. Interrupted by the war, it was resumed with the aid of the Rockefeller Foundation. In this era California was blessed briefly by the leadership of Wilfred Kellogg† as secretary of the board and his long-time service as its chief of laboratories. Walter Dickie,‡ succeeding Dr. Irving Bancroft in August, 1920, served during the entire decade of the twenties whilst the local health departments spurred ahead. Throughout this crucial era, Dr. Robert Peers was the veteran board member who provided continuity, a figurative as well as a literal tower of strength.

The reorganization of the board with establishment of the department in 1929 did not have its major impact for another 15 years. In the meantime, during the thirties, there was a period of instability, and insecurity. During that dark age, with state directors holding office only at the pleasure of the Governor, the state directors' mortality rate was prodigious. The ideal was palsied.

Finally, however, with the appointment of Wilton Halverson§ in 1943, the department stabilized, the board assumed its appropriate advisory role and tremendous progress ensued. In the Warren-Halverson practical idealism, when the State Public Health Assistance Act was passed in 1947, the implementing conference of local health officers effected a major transformation in the form of our ideal. State and local departments staffed by full-time personnel function in a unity which must gladden the souls of Logan and Foster. In this era, too, began the planning for this unifying

\* Sawyer, Wilbur A., M.D., State Health Officer, 1915-1918.

† Kellogg, W. H., M.D., State Health Officer, 1918-1920.

‡ Dickie, Walter M., M.D., State Health Officer, 1920-1931 and 1935-1940.

§ Halverson, Wilton L., M.D., State Director of Public Health, 1943-1954.

headquarters building located to enable the extension of the traditional teamwork between the state department and the School of Public Health of the university. The most eloquent proof of the maturity of the department was the smoothness of the transition from Governor Warren to Governor Knight and from Director—now our university's professor, chairman and dean—Halverson to Director Merrill. The idealism and progress continue and accelerate. Now for the first time the department has achieved a unity of form which matches its unity of spirit.

In this panorama attention has centered on a few of our public health statesmen. Notable among them is the board's veteran consultant, Karl F. Meyer, the Director of the George Williams Hooper Foundation for Medical Research. Karl Meyer's ideals have kept California's public health safeguarded scientifically, but even more importantly, he has served as its lighthouse, protecting it from shoals and reefs and illumining the way ahead with the prophetic vision of a Logan. However, there are scores and hundreds of the other professional and secretarial personnel whose dedicated lives really are the substance of the old board and now the department. Guy Jones, our historian, sage and early health educator; Florence Ames,\* our nurse-epidemiologist who could sniff out the grandmaternal typhoid carrier with matchless precision; Milton Duffy,† whose Bureau of Food and Drug and Cannery Inspection lead the Nation; Eleanor Middlehoff,‡ whose parting devotional was the codification of our regulations and whose fierce and unreconstructed loyalty to her beloved board never would admit that the department was anything but a vermiform appendage: their ideals truly have been as indispensable to the status and stature of this symbolic building as Logan's, Foster's, Sawyer's, Kellogg's, Dickie's or Halverson's. And the same is true of Merrill's men, a team which now encompasses not only the staff of the headquarters but also the campus across Oxford Street and the loyal

local health departments throughout our State. This splendid building is a materialization for this heritage of ideals.

Let all of us who serve in its walls heed these words of Pasteur so fittingly engraved in his shrine, Pasteur's serene benediction:

"Blessed is he who carries within himself a God, an ideal, and who obeys it; ideal of art, ideal of science, ideal of the fatherland, ideal of the Gospel virtues; they all reflect light from the Infinite."

### Sanitation Laboratory Chief Named

Arnold E. Greenberg, Associate Sanitary Microbiologist with the department since July 1, 1954, has been appointed Chief of the Sanitation Laboratory in the department's Division of Laboratories. He succeeds Floyd Hartmann, Sc.D., who had previously been appointed to the position of Assistant Chief of the Division of Laboratories under the Division Chief, Howard L. Bodily, Ph.D.

Mr. Greenberg holds a reserve commission with the Public Health Service and is currently completing work at the University of California toward a Ph.D. degree. He obtained a master's degree in bacteriology at the University of Wisconsin and a master's degree in sanitary science from the Massachusetts Institute of Technology. Prior to joining the department, he was employed for four years in the Sanitary Engineering Research Laboratory of the University of California.

### PHS to Conduct VD Seminar In San Francisco May 26-27

A seminar open to personnel in medical, public health, education, law enforcement and allied fields who participate in or have an interest in venereal disease control programs will be held in San Francisco May 26th-27th under sponsorship of the U. S. Public Health Service. This is the annual seminar for the Western States. Facilities for the meeting are being provided by the San Francisco Health Department at 101 Grove Street.

Topics will include the National Venereal Disease Control Picture Today, Migrant Labor and Venereal Disease Control, Selective Bloodtesting Programs in the Control of Syphilis,

Gonorrhea Control, Medical Aspects of Syphilis Control, Venereal Disease Control in Preventive Medical Program, Promiscuity as a Factor in Venereal Disease Control, Nursing in VD Control and Scientific Aids in Venereal Disease Education.

Teaching staff will include C. A. Smith, M.D., Director, Venereal Disease Service, United States Public Health Service, and other experts brought together from various parts of the Country by the Public Health Service for this meeting.

Copies of the complete agenda may be obtained from the San Francisco Regional Office of the Public Health Service, Room 441, Federal Office Building, San Francisco 2, or from the California State Department of Public Health, 2151 Berkeley Way, Berkeley 4.

### Annual Mussels Quarantine Established May 1

California's annual summer quarantine on mussels went into effect May 1st along the entire coast of the State, including the shores of San Francisco Bay. This ban on the sale and offering for sale of mussels, which is established by the State Board of Public Health, is usually lifted on October 31st, but may be extended if laboratory tests show that the edible flesh of mussels still contains the deadly toxin secreted by the microscopic organism *Gonyaulax catenella*. Ocean waters teem with this organism during the warm months of the year.

Five cases of mussel poisoning, but no deaths, were reported in California last year, California's first since 1948. The mussels had been gathered along the Sonoma and Marin coasts.

Health officers of the coastal and bay counties are instructed to post suitable placards in conspicuous places advising the public of the annual quarantine. The placard shall also warn the public that clams should be cleaned and washed thoroughly before cooking. While clams are not included under the quarantine, the toxin may be present in the dark parts of the meat and only the white meat should be prepared for human consumption. In addition, clams should be taken only from areas free from sewage contamination.

\* Miss Ames joined the department in 1923 and retired in 1947.

† Mr. Duffy joined the department in 1914, and since 1932 has been chief of the Bureau of Food and Drug Inspections.

‡ Mrs. Middlehoff joined the department in 1907, serving under 11 state health officers up to her retirement in 1945.

## NURSING HOMES IN CALIFORNIA

The following report of a survey on nursing homes in California has been prepared by the Bureau of Hospitals, State Department of Public Health. It is part of the survey of nursing care institutions conducted by the Commission on Chronic Illness with the assistance of the United States Public Health Service to secure facts on which a better understanding of nursing homes and the part they play in the care of the chronically ill can be based. California was one of 12 states participating in the survey.

The Commission on Chronic Illness is an independent national agency founded jointly by the American Hospital Association, American Medical Association, American Public Health Association, and the American Public Welfare Association.

### INTRODUCTION

The State Department of Public Health, in cooperation with the Commission on Chronic Illness, has completed a survey of patients in nursing homes in California. Purpose of the survey was to determine the types and characteristics of patients in nursing homes in California and to gain some information regarding type, size, ownership, and staffing of the homes which accommodate these patients and which are licensed by the State Department of Public Health.

Because this type of institution provides care primarily to older people, who are becoming a larger segment of our population, the nursing home is assuming an increasingly important role in the institutional care program of the State. Interest in these facilities has increased markedly in the past few years. This interest has resulted in state legislation which established a licensing program and in organization of nursing home associations. Recent congressional action provides financial assistance to nonprofit groups in nursing home construction as part of the hospital survey and construction programs.

This report contains findings of the survey and a brief resume of the nursing home licensing program in California.

### Selection of a Sample

A sample of nursing homes was used as basis for the study. The method of selecting the sample, as well as collecting, processing, editing, coding and tabulating the data, has been in accordance with methods set up by the Commission on Chronic Illness. As a result, comparable data will be obtained from all 12 states which participated in the study.

The commission suggested that a 25 percent sample be used. Institutions in the sample were selected from metropolitan, suburban, and rural areas and including institutions with and without registered nurses on their staffs. All sizes of institutions were represented in the same proportion as they occur in the State. Because nursing homes in California tend to be fairly small, 40 percent of all the homes in the sample were under 10-bed capacities. Since there were only 10 institutions of 60 beds or more, all 10 were included in the study, but only 25 percent of patients in each institution were included.

In California, 126 nursing homes were surveyed. These homes had a total licensed capacity of 3,047 beds and at the time survey was made, were housing 2,558 patients. This constituted 25.9 percent of all licensed nursing homes and represented 32.8 percent of the total licensed nursing home beds in the State.

The data were collected on two forms, both of which were furnished by the Commission on Chronic Illness. The information on one form related to characteristics of the institution such as staffing, size, location, etc., and the other related to characteristics of the patients, such as physical and mental condition, age, sex, diagnosis, disability, etc.

Because this study was aimed at determining the characteristics of aged patients in nursing, convalescent, and rest homes, children's convalescent homes were not included in the study.

### Definition

A nursing, convalescent or rest home, according to the licensing requirements as found in Title 17, Section 235, California Administrative Code, is defined as follows:

"Nursing, convalescent or rest home is any place or institution which makes provisions for bed care, or for chronic or convalescent care for two (2) or more patients, exclusive of relatives, who by reason of illness or physical infirmity are unable to properly care for themselves. Persons providing such care in their homes, with or without compensation, for less than two (2) persons at any one time, shall comply with all public health regulations and shall maintain standards equivalent to the requirements of the State Department of Social Welfare for boarding homes. Alcoholics, drug addicts, persons with mental diseases, and persons with communicable diseases, including contagious tuberculosis, shall not be admitted or cared for in nursing, convalescent, or rest homes licensed under these requirements."

At the time of the survey, there were 487 licensed nursing, convalescent and rest homes, excluding children's homes, in California. These homes had accommodations for 9,288 patients.

### SECTION I. CHARACTERISTICS OF NURSING HOMES

#### A. Ownership

Of the 126 nursing homes in the sample, all but six were proprietary. This is representative since most of the homes in the State are privately owned and are operated for profit. Those homes which operate on a nonprofit basis are usually owned by fraternal and religious organizations.

#### B. Size

As already stated, there are many small nursing homes in California and only a few large ones. While the average is 19 beds, 42 percent of the homes

have less than 10 beds and only 5 percent of the homes have accommodations for 50 or more patients. Only 3 homes in the entire State have capacities of more than 100 beds.

#### C. Occupancy

The survey revealed that the average occupancy of the nursing homes in the State was higher than is found in general hospitals. The average occupancy on day of the survey was 81 percent. While the highest occupancy was found in establishments with over 50 beds, the size did not seem to be the factor which determined occupancy. The high occupancy is partly explained by the fact that the turnover in these chronic care facilities is very slow and partly by the fact that there is a fairly large demand for this type of medical care institution, particularly in some areas of the State. Many nursing homes maintain a waiting list which is resorted to when a vacancy occurs. Thus the bed is immediately occupied.

#### D. Age of Establishment

The survey disclosed that 18 percent of the nursing homes have been operating less than a year under the present ownership. Seventy-three percent have operated with the present owner less than five years. It is known that this type of facility, particularly the small one, tends to have relatively frequent changes in ownership.

#### E. Skill-level of Staff

To determine the highest level of skill available in the nursing homes, the study includes the number of licensed professional nurses which are employed, as well as the size and number of homes which employ licensed professional personnel. Fifty-eight percent of the nursing homes have registered nurses on their staffs. It was found that registered nurses are always employed in the larger facilities and less often in the smaller ones. Licensed vocational nurses are employed as the highest skill-level in 13 percent of the nursing homes. The 30 percent which do not employ registered nurses or licensed vocational nurses have capacities of less than 25 beds, and most of them have capacities of less than 10 beds. It should be noted here that 76 percent of all patients are accommodated in nursing homes which employ registered nurses.

#### F. Staffing

In the nursing homes which are staffed with professional nurses, the ratio of registered nurses to patients is 1:12. The study revealed that for all nursing personnel (licensed, unlicensed, etc.) in all nursing homes in the State, the ratio of one such person to every 2.5 patients exists.

When all personnel are considered (nursing, dietary, administrative, etc.), the study reveals that there is one employee for every 1.8 patients.

### SECTION II. CHARACTERISTICS OF PATIENTS

#### A. Age

As is to be expected, most of the patients in California's nursing homes are in the elderly age group. The median age for both sexes is 80 years; it is slightly higher for women than men. This extremity of age is impressive, particularly since 69 percent of all patients in these homes are over 75. Problems associated with old age, as well as those associated with long term illness, must receive consideration in homes which accommodate this group of our aging population. Twenty-eight percent are 85 years or older. Less than 1 in 10 patients is 65 years or younger and from the survey, it appears that there is a higher percentage of men in this younger age group than women.

#### B. Sex

Women outnumber men in nursing homes by  $2\frac{1}{2}$  to 1. This is partly accounted for by the fact that the life span of women is somewhat longer than that of men. This preponderance of women in nursing homes is in contrast to county hospitals, where the majority of patients being provided nursing home type of care are men.

#### C. Marital Status

It is not surprising to find that 64 percent of the patients are widowed, 14 percent have never been married, and 12 percent are married. While the percentage of single men and women in nursing homes is about the same, 70 percent of all the women but only 49 percent of the men are widowed. Only 8 percent of the women are married, while 24 percent of the men are married.

While less than 2 percent of all patients are divorced, the percentage of divorced men is eight times higher than among women.

#### D. City of Residence

The study revealed that most of the patients entered a nursing home in the same vicinity as their home. Only a few go out of the county in which they live.

#### E. Length of Stay to Date

Nearly half of the patients have been in the nursing home at least one year. While 8 percent have been living in a nursing home more than five years, 11 percent have been patients there less than one month. While this does little more than indicate the extremely long stay of the long-term patient, it points to the problems, especially the financial ones, which must be encountered in providing care for the elderly patient.

The patients with diagnosis of senility and arthritis tend to have a longer stay in the homes, while the patients with heart disease tend to have a shorter stay than other types of patients.

### SECTION III. MEDICAL DIAGNOSIS AND MEDICAL ATTENDANCE

#### A. Medical Diagnosis

The most common primary diagnosis among both men and women is hemiplegia or paralytic stroke. This accounts for almost one-fourth of all patients. The second commonest is senility. This is followed by diseases of the circulatory system other than heart disease. However, if all diseases of the circulatory system, including heart disease but excluding hemiplegia, are considered together, this group would be second in prevalence—about 20 percent. Heart disease comes next, followed by hip fracture, which accounts for 8 percent of all diagnoses. It is interesting to note that 9 percent of all women patients in nursing homes have suffered from hip fracture, while only 3 percent of the men have suffered such injury. Except for this diagnosis, there is not much difference of diagnosis in sexes.

Hemiplegia is a little more common among men, while senility and arthritis is somewhat higher in women.

The study showed that 6 percent of all patients have arthritis and rheumatism and 3 percent have diabetes.

In the age group under 55, multiple sclerosis, hemiplegia, and other paralysis are listed as primary diagnoses in the order mentioned. In the 55-64 age group, hemiplegia, heart disease and other circulatory diseases rank highest; in the 65-74 age group, hemiplegia, circulatory diseases, and arthritis and rheumatism account for the most common diagnoses. Among the 75-84 age group, hemiplegia, senility, and circulatory diseases are most common, and in the extreme age group, 85 and over, senility, hemiplegia, and circulatory diseases rank highest.

#### B. Medical Attendance

The survey showed that 3½ percent of the patients have not been visited by a physician since their admission. A third of these have been in the nursing home less than a month.

Sixty-five percent of the patients have been seen by a physician during the preceding month. Of this group, half have been seen only once by a physician and the remaining half averaged about four physician visits.

Fifteen percent have not been visited by a physician during the preceding three months. While more of this group have the diagnosis of senility than any other, this percentage represents all diagnoses. The above indicates to some degree the amount of medical care being provided to patients in nursing homes. There is reason to believe that the patient with diagnosis of senility is receiving the least medical attention. Eighty percent of the patients with heart disease have been seen by a physician within the previous month, but less than half of those with senile diagnosis have been seen within the same period of time.

### SECTION IV. DEGREE OF DISABILITY

#### A. Bed Status

One patient in three, regardless of age is a strict bed patient and is confined to his bed all the time. About the same number is considered to be ambulatory. This type of patient usually is able to exercise, go to the bathroom and return to his bed for resting and sleeping. The third group is in bed part or most of the time. They can sit

up in bed, be placed in a chair, walk with assistance, or may be up for short periods of time. It is recognized that the last named group often requires as much or more extensive and skilled nursing care and attention than the completely bedfast patient.

The largest proportion of completely bedfast patients, and the smallest proportion of ambulatory patients, are found in the age groups below 65 and above 85. This may indicate that the age group under 65 needs bed care mainly because of illness while the oldsters require bed care because of physical disability due to advanced age.

#### B. Mental Condition

Mental disorientation among patients also showed up in the study. Nearly 60 percent of the patients are confused at least part of the time. As would be expected, the extremely aged group shows the highest percentage of disorientation and the younger group the lowest.

#### C. Continence

Forty-three percent of the patients are reported as incontinent, having no control over bowels, bladder, or both. Here again, the age groups at the two extremes show the highest number of patients afflicted with this condition. While continence is not always a good indication of a patient's general condition, it shows the amount of nursing care and attention which is required. In this connection, it should be recognized that skilled professional care and supervision can, in many instances, prevent this condition as well as reduce its occurrence.

### SECTION V. PATIENT SERVICES

In addition to the types of services which have already been mentioned and are considered necessary in connection with patients' disabilities, the survey reveals further requirements for patient care in California's nursing homes. A third of the patients need help in feeding. This time-consuming aspect of patient care almost always involves coaxing and encouraging, as well as actually giving physical assistance.

Almost half of the patients need help in dressing. Two-thirds of the patients require bed baths. Most of the remaining require help with a tub bath. Half

of the patients require the use of the bed pan. This again indicates the amount of nursing care involved, especially since many of the patients who can go to the bathroom must be given assistance in getting there and back to bed. About as many require enemas.

Seven out of every 10 patients are getting medications regularly. The interval of such administration ranges from once a week to several times a day. A fourth of the patients require hypodermic injection of medication. Only 8 percent necessitate surgical dressings.

More than one-fourth of the patients have special diets prescribed. The most common is the low-salt or salt-free diet. This constitutes the diet prescribed for 17 percent of the patients, which is not surprising when it is remembered that the primary diagnosis for one-fourth of all patients is hemiplegia. Soft or pureed, diabetic, and liquid diets are listed, along with other less common special diets.

The study shows that only 2 percent of the patients require no assistance in caring for themselves, and have no medications or special diets prescribed for them in the nursing home.

### SECTION VI. PATIENT CARE NEEDS

Based on the type of care which is provided the individual patients, the operators were requested to state whether the care which is provided consists mainly of boarding home care, whether it is the type of care which is possible to provide in one's home, or whether it is the type of care which would be difficult and impractical to provide in one's home. It should be recognized that the results were expressions of opinion.

The opinions expressed were that less than 10 percent of all patients are boarding-home type of patients. This small percentage of patients is receiving the minimum of services in the nursing homes. Most of the services consisted of board and room and of other minimal personal care services which might be required. Medications, bed baths, use of bedpans, enemas, etc., are not necessary for this type of patient.

Eighteen percent of the patients, according to the persons interviewed,

could be cared for in one's home, although the care is in excess of room and board. Assistance in feeding, dressing, walking, shaving, and bathing might be necessary, as well as medications, special diets, etc. However, detailed and skilled nursing care is not required and it is feasible that the necessary services might be provided in one's home.

The remaining patients, almost three-fourths of the total, require services which were considered impractical to provide in one's home by the persons interviewed. These patients, in addition to requiring assistance in feeding, dressing, and bathing, require more skilled services, such as medications, hypodermics, special diets, catheterizations, enemas, and dressings.

#### SECTION VII. CHARGES AND SOURCE OF FUNDS

##### A. Charges

The monthly charge made by the nursing home for the care of the patient ranges from no charge or free care to over \$300.

At one extreme, 4 percent of the patients are paying less than \$60 per month for care, while at the other extreme 6 percent are paying \$300 or more per month. More than half of the patients are being charged less than \$200 per month, but 59 percent are paying between \$150 and \$250 per month.

##### B. Source of Funds

Thirty-two percent of the patients are receiving care which is paid in part or in total by some welfare agency. Twelve percent are cared for wholly by public welfare. The other 20 percent receive care which is paid for from multiple funds, usually from one or a combination of welfare funds supplemented by money from private

funds, such as funds from relatives or friends of the patients.

The State Department of Public Health wishes to express appreciation to operators of the nursing homes which were included in the survey for their assistance and cooperation in the collection of the data which made the survey possible. It is hoped that the results will be valuable to nursing homes, nursing home associations, community health and welfare agencies, as well as to other individuals and groups who are interested and concerned with the care and welfare of the aged.

### Public Health Positions

#### Orange County

**Sanitarian:** Immediate opening. Salary range, \$337 to \$417. Registration by the State of California as a sanitarian required. Selection will be made on the basis of a personal interview. Apply Orange County Personnel Department, 644 North Broadway, Santa Ana.

#### Placer County

**Public Health Nurse:** Salary, \$295 to \$358. Salary raises anticipated at completion of current salary survey. Qualified person may start above the minimum. Car required, 8-cent mileage allowance. For further information write Ruth M. Moldenhauer, M.D., Director, Placer County Health Department, 360 Elm Street, Auburn.

#### State of California

**Assistant Industrial Hygiene Engineer:** Salary range \$415 to \$505. Filing deadline is May 27th and the examination will be held June 18th. The current vacancy is with the State Department of Public Health. Entrance requirements include the equivalent to graduation from college with major work in engineering, plus two years of experience in general engineering work, at least one year of which shall have been in public health engineering. Completion of a one-year postgraduate course in public health engineering may be substituted for one year of the required experience.

### Redwood Empire's Health

The Humboldt-Del Norte Health Department, with headquarters in Eureka, has initiated a mimeographed monthly bulletin entitled "Redwood Empire's Health." Its first issue in February interpreted through illustrations the department's organization and services. John A. Carswell, M.D., is director of the bicounty department.

**GOODWIN J. KNIGHT, Governor**  
**MALCOLM H. MERRILL, M.D., M.P.H.**  
State Director of Public Health

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Entered as second-class matter Jan. 25, 1949,  
at the Post Office at Berkeley, California, under  
the Act of Aug. 24, 1912. Acceptance for mailing  
at the special rate approved for in Section  
1103, Act of Oct. 3, 1917.

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